THE RECOVERY KERNEL

How to Navigate the Recovery Kernel

For People Recovering from GHB, GBL, and 1,4-BD

A step-by-step route: what to read, in what order, and what outcome the Kernel projects if you follow it.

> **HARM REDUCTION RESOURCE — NOT MEDICAL ADVICE. GHB WITHDRAWAL CAN CAUSE FATAL SEIZURES AND DELIRIUM.** If you dose more than three or four times a day, or dose overnight to prevent withdrawal, do not stop on your own. Go to an emergency department.
>
> There is no antidote for GHB overdose, and naloxone does not work on it. If someone is unresponsive or breathing slowly: call 911, place them on their side, and stay with them.
>
> Crisis: call or text 988 · SAMHSA: 1-800-662-4357

1. Before you start

This is a route through the Recovery Kernel for people recovering from GHB, GBL, or 1,4-butanediol, and for people prescribed sodium oxybate (Xyrem) who need to reduce or stop. It is also for the people supporting them. The biology is the same across all four forms. The medical urgency depends on how often and how much you dose. Four rules set the order of everything that follows.

- **Triage before anything.** How dependent you are decides whether Step 1 is an emergency department or a same-day physician conversation. Answer the Step 0 questions honestly first.
- **Medical safety before biology.** For anyone dependent, the Kernel framework does not begin with the Compendium. It begins with supervised medical management (Supplemental Ch. 10, Section 7).
- **The timeline is the longest in the library.** The central restoration phase runs 3 to 6 months, and substantial receptor recovery takes 12 to 18 months or more (Supp. Ch. 31 §2). Expecting a 4 to 8 week timeline is how people conclude, wrongly, that recovery has failed.
- **Do not wait for test results to start.** The genome refines the plan. It never gates the detox decision (Main Book, Quick-Start Step 3; Supp. Ch. 5, Step 1b).

How chapters are cited. "Main Book" is the Recovery Kernel Main Book (Second Edition, Centurian). "Compendium" is the Complete Protocol Compendium. "Supp. Ch. N" is chapter N of the Supplemental Book: Chapter 10 (How to Recover from GHB) and Chapter 31 (Discontinuance Protocol: GHB / GBL / 1,4-BD) are the two core chapters. Section numbers (§) refer to sections inside those chapters.

A note on protocol numbers. Supplemental Chapters 10 and 31 cite Compendium protocols by number, and some numbers do not match the Compendium as printed. Chapter 10 calls Protocol 05 "environmental redesign" and Protocol 20 "identity reconstruction"; the Compendium prints Protocol 05 as Digital Detox and Protocol 20 as Mapping the Terrain. Chapter 10 calls Protocol 04 "Dharma Recovery"; the printed title is Meeting Alternatives. Both chapters also cite a "Protocol 35S series" for chemsex that is not in the provided Compendium text: use Supp. Ch. 29 instead. This guide cites each protocol by its printed title and number. If a number and a title disagree, follow the title.

For GHB, the sharpest version is redosing before the first dose has even finished arriving — GHB’s steep dose curve is why “it doesn’t feel like it worked yet” is the most dangerous thought in this guide.

Redosing is not the only version of this. Watching peers in a treatment setting negotiate a relapse, getting confident advice from someone untrained in your specific situation, or noticing a prescriber treat a prescribed substance more casually than an illicit one can all trigger the same pattern: a felt doubt read as “the plan must be wrong,” answered by abandoning it. See **The Commandeering Map**, a companion to this series, for the fuller pattern, including how it can differ by genetic profile and what helps when practice-based resistance alone is not enough.

2. The route at a glance

Steps 0 and 1 come first and cannot be skipped. Steps 2 to 4 can run at the same time once you are medically stable. Steps 5 to 9 overlap and are the work of the first two years. Step 10 is everything after. "P" means Compendium Protocol; "C" means Centurian Paper.

Step	When	What you do	Turn to
0	Day 0	Triage: how dependent are you? Know the overdose signs. Never mix. Never withdraw alone.	Supp. Ch. 10 §0 Supp. Ch. 31 §§0, 7 Main Book, Quick-Start Step 1
1	Days 0–7 (dependent use)	Supervised detox in an emergency department or inpatient unit. Plan for day 30.	Supp. Ch. 31 §§1–2, 8 Supp. Ch. 10 §§3, 8 Supp. Ch. 8, 9, 30 if co-use
2	Weeks 1–4 (once stable)	Read the Main Book in order.	Main Book: Who This Book Is For, Quick-Start, Part One (Ch. 1–5) Supp. Ch. 2, 3, 4
3	Weeks 1–4	Order 30× whole-genome sequencing. Add a clinical PGx panel and baseline labs.	Supp. Ch. 5 Step 1 Supp. Ch. 10 §2 Compendium P06
4	Weeks 2–6	Resolve your combined profile. Carry a prescriber card.	Supp. Ch. 5 Steps 2–3, 6 Supp. Ch. 4 Supp. Ch. 31 §5
5	Day 1 post-detox to Month 6	Build the biological foundation with your physician.	Supp. Ch. 10 §4 Supp. Ch. 31 §9 Compendium P17, P18, P09, P07, P10
6	Weeks 2–12, then ongoing	Remove cues, including apps and chats. Learn the four craving types and the interrupt.	Supp. Ch. 10 §5 Supp. Ch. 31 §7 Compendium P20, P21, P08, P33
7	Months 1–18	Rebuild your own GABA: breath, cold, exercise, stillness.	Supp. Ch. 10 §6 Supp. Ch. 31 §9 Supp. Ch. 36; Compendium P19, P03, P04
8	In parallel	Rebuild sleep. Manage anxiety without opening a second dependence.	Supp. Ch. 10 §§4.4, 8 Supp. Ch. 31 §8 Compendium P17, P13, C-32
9	Months 1–12+	Context work (chemsex, athletic use, narcolepsy), then identity, inventory, work, family.	Supp. Ch. 29, 42, 43, 51 Compendium C-28, P23, P24, P22
10	Year 1 to Year 10	Steward: review, transplant, mentor.	Supp. Ch. 44, 6, 38 Compendium P02, P13 Supp. Ch. 5 Step 6

3. The route, step by step

Step 0 — Triage (Day 0, before everything)

Answer these honestly. A yes to any of them means medical detox, not self-management: Are you dosing more than three times a day? Do you shake, sweat, or feel extreme anxiety when you miss a dose? Have you ever had a seizure, confusion, or hallucinations when going without? Are you dosing every two hours, or overnight, to prevent withdrawal? Do you regularly use alcohol or benzodiazepines alongside GHB?

The Kernel then sorts use into five levels. Levels 1 and 2 (rare or occasional, not escalating) can usually stop without medical care. Level 3 (roughly weekly, stable, no withdrawal symptoms between uses) is very likely safe to stop without inpatient detox, but talk to a physician the same day to rule out dependence you have not noticed. Level 4 (escalating, or any discomfort between doses) means physician involvement before stopping is a safety requirement. Level 5 (three or more doses daily, including nocturnal dosing) means supervised detox only.

Know the overdose signs: cannot be roused, slow or stopped breathing, blue or gray lips, vomiting while unconscious, seizure. Sedation, unconsciousness, and respiratory failure can follow each other within minutes, and the dose that sedates and the dose that kills are close together. Never combine GHB with alcohol or any other depressant. Street GHB has no standard concentration, so the same volume can hold very different doses. Keeping a large supply on hand is its own risk factor.

Turn to: Supp. Ch. 10 §0 (who needs medical detox; overdose recognition and response; the dose-measurement problem). Supp. Ch. 31 §0 and §7 (use-pattern levels; hoarding a supply). Main Book, Quick-Start Boot Sequence, Step 1. Compendium Protocol 01, Emergency Triage, for an acute crisis state.

Step 1 — Medical detox (Days 0–7 for dependent use)

Withdrawal in a dependent user can begin within 2 to 6 hours of the last dose. The peak-danger window is roughly 12 to 72 hours, with a real risk of seizure and a severe delirium that involves agitation, confusion, hallucinations, and autonomic instability. There is no FDA-approved treatment specific to GHB withdrawal. The Kernel presents baclofen, which acts on the same receptor system as GHB, as the most evidence-supported option. High-dose benzodiazepine protocols are what emergency departments most often use, and phenobarbital and pharmaceutical sodium oxybate tapers exist in specialist settings. Many physicians have limited GHB experience, so knowing the options lets you or a supporter advocate for the right care. The Kernel does not give a self-administered protocol, and neither does this guide.

Signs to go to an emergency department immediately: any seizure, however brief; confusion, disorientation, or hallucinations; extreme agitation with a racing heart, high blood pressure, or heavy sweating; a tremor that is getting worse. Never withdraw alone from a dependent pattern. If a hospital is genuinely out of reach, poison control lines and telehealth exist for this gap, and a sober person physically present is the minimum safeguard.

> **The 30-day cliff.** A common discharge pattern is about 5 days inpatient followed by a benzodiazepine supply of about 30 days as a bridge. When that supply ends on a calendar date, with no taper and no follow-up booked, relapse is documented and common, because the GABA-B system is still months from recovery. Before you leave: book an outpatient appointment dated before the supply runs out, and ask for a taper coordinated with an addiction medicine or psychiatric provider, not a hard stop. (Supp. Ch. 31 §8)

Turn to: Supp. Ch. 31 §§1–2 and 8 (why this withdrawal is different; timeline; detox options; limited hospital access; the 30-day cliff). Supp. Ch. 10 §3 (3.1 why it is uniquely dangerous, 3.2 medical options, 3.3 timeline, 3.4 PAWS) and §8. Supp. Ch. 31 §10 (emergency recognition, restated). Do not add supplements during a baclofen or benzodiazepine taper without your physician: some, such as lemon balm, valerian, and high-dose taurine, add sedation (Supp. Ch. 10 §4).

Special situations. Prescribed sodium oxybate for narcolepsy: stopping needs your neurologist, because the narcolepsy symptoms return, and alternatives should be optimized first (Supp. Ch. 31 §6). Alcohol used as well, or GHB used as an alcohol substitute: assess both dependencies together before reducing either (Supp. Ch. 8). Benzodiazepines used as well: Supp. Ch. 9 and Supp. Ch. 30. Chemsex: Supp. Ch. 29.

Step 2 — Read the Main Book (Weeks 1–4, once medically stable)

Read it in order once you are physically stable. If you are overwhelmed, the Quick-Start Boot Sequence is designed to be read on its own. Read "Who This Book Is — and Is Not — For" first: it names the situations where the supplement protocols need medical modification, including active psychosis, pregnancy, and severe liver disease.

Read in this order: Who This Book Is For → Quick-Start Boot Sequence → Part One: Ch. 1 (Why Willpower Isn't Enough), Ch. 2 (MTHFR), Ch. 3 (COMT), Ch. 4 (CYP450, relevant to how baclofen and benzodiazepines are processed), Ch. 5 (When Systems Collide) → Ch. 7 (Harm Reduction), only if you are still using → Part Two, the case files (Chapter 6). Ch. 8 (Oxytocin Protocol) is experimental and specialist-only. Ch. 9 (Epigenetic Playground) belongs to Steps 7 and 10. Appendix A (clinical tables) and Appendix B (AI prompts) are reference.

Then add: Supp. Ch. 4 (The Braking System: GABRA2 and GABRB3), which is the most important supporting chapter for GHB. Supp. Ch. 2 (Clarity · Restoration · Manning), which includes Case 10, the GHB case, and sets your expectations. Supp. Ch. 3 (The Addict Virgin Problem), which recalibrates timelines for a damaged system. Supp. Ch. 1 (Why They Left You There) is optional reading for the shame; the Kernel notes that GHB users are often invisible to the systems that would help them.

Step 3 — Get your DNA (Weeks 1–4)

The Kernel's recommended route is 30× whole-genome sequencing, which returns a VCF file, a one-time asset you keep. A consumer SNP array is an acceptable start. A clinical pharmacogenomic panel adds clinical-grade CYP2C19 and CYP3A4 calls. Homocysteine, B12, and RBC folate are functional markers you can recheck quarterly.

For GHB, the single most important gene is **GABRA2** (the rs279858 and rs279845 high-risk haplotypes). The Kernel says it explains the severity of dependence, of withdrawal, and of PAWS, and recommends testing it as early as possible. Next come COMT, MTHFR, DRD2/ANKK1, and SLC6A4, plus GABRB3 (seizure threshold, Supp. Ch. 4). CYP2C19 and CYP3A4 matter because they govern how baclofen and benzodiazepines are metabolized, so give any known result to your detox physician. ADH1B and ALDH2 matter if you used 1,4-BD, because that pathway converts it to GHB in the liver. GABBR1 and GABBR2, the genes for the receptor GHB acts on, are the most GHB-specific of all, but clinical testing is currently limited. Until results arrive, use the free phenotype self-assessments.

> **Confirm what you are ordering.** Supp. Ch. 5 specifies 30× whole-genome sequencing with VCF output. "WGBS" more commonly names whole-genome bisulfite sequencing, a DNA-methylation assay that is not built to call variants such as MTHFR C677T. Ask the lab for a standard variant file (VCF).

Turn to: Supp. Ch. 5, Step 1 (test options; free phenotype estimates). Supp. Ch. 10 §2 (DNA testing panel for GHB recovery). Compendium Protocol 06, Phenotype Assessment. Main Book Ch. 2 and Ch. 3 self-assessments. Supp. Ch. 4 (braking-system assessment).

Step 4 — Resolve your combined profile (Weeks 2–6)

The Kernel separates two questions. Who is most likely to become dependent? GABRA2 high-risk combined with COMT Met/Met, the "Anxious Depressant" profile and the Kernel's "Hard Fail" combination for GABAergic substances: a structurally underpowered brake plus a nervous system that will not quiet. Whose withdrawal and taper will be hardest, whatever their reasons for using? GABRA2 high-risk combined with GABBR1 or GABBR2 variants, because those are receptor-level genes. COMT tells you why you used and what your long-term recovery must aim at, not whether a taper works. Write your profile down and carry your key results on a card.

If your result is...	What changes	Source
GABRA2 high-risk	Weak inhibitory brake. Slower GABA restoration, more severe PAWS. Natural GABA-building practice is non-negotiable. Alcohol and other GABAergic substances are the "Hard Fail" hazard.	Supp. Ch. 10 §2; Ch. 31 §5
COMT Met/Met (Sage)	Over-represented in anxiety-driven use. Long-term recovery aims at calm-building.	Supp. Ch. 31 §5; Ch. 5
COMT Val/Val (Warrior)	More common in chemsex or stimulant-counterbalance use. Needs stimulation management and high-intensity outlets, not only calm.	Supp. Ch. 31 §5; Ch. 29
GABBR1 / GABBR2 variants	Affect sensitivity to GHB and severity of receptor downregulation. With GABRA2, predict a slower taper and harder PAWS. Testing limited.	Supp. Ch. 31 §5
MTHFR	5-MTHF is foundational. Start low: rapid methylation can worsen anxiety early in recovery. Avoid synthetic folic acid with any T variant.	Supp. Ch. 10 §4.1; Main Book Ch. 2

If your result is...	What changes	Source
DRD2 A1 and SLC6A4 s/s	DRD2 A1: build dopamine reward sources or the pull remains. SLC6A4 s/s: high anxiety sensitivity, so support serotonin alongside GABA.	Supp. Ch. 10 §2; Ch. 5 System 5
CYP2C19 / CYP3A4	Poor metabolizers accumulate baclofen at standard doses; ultrarapid metabolizers may need more. Tell your detox physician.	Supp. Ch. 10 §2; Ch. 31 §5
ADH1B / ALDH2	1,4-BD users: compounding conversion conflicts with alcohol. Liver function testing is a priority.	Supp. Ch. 31 §5

Turn to: Supp. Ch. 5, Steps 2, 3, and 6 (gene systems, combined profiles, profile template). Supp. Ch. 4. Supp. Ch. 31 §5 (genetic cross-reference; "who is actually most at risk"). Main Book Ch. 5 and Appendix A.

Step 5 — Build the biological foundation (Day 1 post-detox to Month 6)

Begin after a physician confirms you are medically stable, not during the acute window. The foundation has layers: a methylation and B6 base (active B6 is the cofactor that converts glutamate to GABA), magnesium glycinate (the Kernel calls it the highest-priority single supplement in GHB recovery), other GABA-supportive compounds, dopamine and serotonin rebuilding once the acute crisis has passed, sleep repair, and nutrition. The dose tables are in the chapters below. Run every addition past a pharmacist and an interaction checker (Drugs.com or Medscape) and tell every prescriber what you take. The peptide layer in Supp. Ch. 10 §4.5 is labeled by the Kernel as needing physician discussion, so it is not a self-start step.

Turn to: Supp. Ch. 10 §4.1 (methylation foundation), §4.2 (GABA-B system restoration), §4.3 (dopamine and serotonin), §4.4 (sleep), §4.5 (peptides, physician only). Supp. Ch. 31 §9 (Tiers 1–3, exercise specifics, nutrition scaffolding). Supp. Ch. 5, Phase One. Main Book Ch. 2, §2.4–2.5. Compendium Protocol 17 (The Nightly Restoration), Protocol 18 (Eating for Restoration), Protocol 09 (The Gut-Brain Axis), Protocol 07 (Neuroplasticity), Protocol 10 (Dopamine Architecture), and Centurian Paper C-32 (The Insomnia Architecture).

Step 6 — Cues, environment, and craving (Weeks 2–12, then ongoing)

GHB cravings have a physical quality that most substances lack. The Kernel describes four types: anxiety-driven (a body-level alarm that feels like early withdrawal), sleep-context (waking two to three hours after sleep onset, the timing of the old dosing schedule), social or chemsex cue, and anhedonia (flatness, in which GHB is remembered as the thing that made everything vivid). The first type is the recovering GABA system oscillating, not evidence that you are in medical danger. But hallucinations, severe confusion, or seizure at any point are a medical emergency, not PAWS.

Reduce what is physically within reach: a large supply makes an impulsive extra dose easier, and concentration can vary from the first measure to the last. Environmental redesign must cover digital environments (apps, chats, groups) as thoroughly as physical ones. If a venue or community has excluded you, be aware that use often moves to being alone, which removes anyone who could recognize an overdose and call for help.

Turn to: Supp. Ch. 10 §5 (four craving types; the 5-minute interrupt). Supp. Ch. 31 §6 and §7 (contexts; hoarding a supply). Compendium Protocol 20 (Mapping the Terrain), Protocol 21 (Reading the Collapse), Protocol 08 (Social Environment), Protocol 33 (The Boundary Architect), Protocol 05 (Digital Detox), Protocol 04 (Meeting Alternatives).

Step 7 — Rebuild your own GABA (Months 1–18)

GHB gave a nervous system that would finally, completely stop. The Kernel's premise is that this state is reachable through the brain's own systems, and that a rebuilt version is more sustainable because it does not downregulate the way GHB's receptor did. The tools: extended-exhale breathwork practiced daily until it is as automatic as the old dosing schedule; cold water; sustained aerobic exercise; restorative yoga and non-sleep deep rest; meditation, which builds over months; nature time; music at 60 to 70 BPM; and absorbing creative practice. Consistency matters more than intensity, and what determines PAWS severity is sustained practice through the whole 3 to 6 month central phase, not a strong first two weeks. Do not taper off supports early. Keep intense exercise out of the evening, and build up gradually, because overtraining early adds stress to a taxed system.

Turn to: Supp. Ch. 10 §6 (natural GABA activation). Supp. Ch. 31 §9 (natural GABA reconstruction; exercise specifics). Supp. Ch. 36 (Roots and Reversal). Supp. Ch. 3 (timeline recalibration). Compendium Protocol 19 (The Body in Motion), Protocol 03 (Sonic Architecture), Protocol 04 (Meeting Alternatives, which includes Dharma Recovery), Protocol 29 (The Peacetime Paradox).

Step 8 — Sleep and anxiety, without opening a second dependence

For people who dosed overnight, sleep is both the most urgent and the hardest thing to rebuild. Expect to wake at the old dosing times for weeks or months, and do not read it as failure. Anxiety arrives in waves, a documented GHB PAWS pattern, not a steady hum. The Kernel warns of a specific trap: post-GHB anxiety gets read as a new anxiety disorder, an open-ended benzodiazepine follows, and the result is a longer dependence than the first. The safeguard is to tell every prescriber about the recent GHB history and timeline, and to ask that anything prescribed be a time-limited bridge with a stated review date. Non-addictive options such as buspirone exist for persistent anxiety, and you can raise them with your prescriber.

Turn to: Supp. Ch. 10 §4.4 (sleep reconstruction) and §8 (medications for co-occurring conditions). Supp. Ch. 31 §8 (the 30-day cliff; how this becomes a second, separate addiction; the disclosure wording). Compendium Protocol 17, Protocol 13 (The Pharma Trap), Centurian Paper C-32. Supp. Ch. 9 and Ch. 30 if a benzodiazepine dependence has already formed.

Step 9 — Context, identity, and rebuilding a life (Months 1–12+, revisited later)

What GHB was doing depends on your context, and recovery must address it. In chemsex, GHB is one part of a polydrug pattern: each substance needs its own recovery track, and sexual health (HIV and STI testing, PrEP status) and building a sober community are clinical priorities. For athletic or bodybuilding use, replace the growth-hormone effect with strength training and deep sleep. For sleep or anxiety self-medication, anxiety management is the central target. For high-frequency users, the drug organized the structure of the day, and removing it can cause temporal and identity disorientation on top of the withdrawal. Full Inventory is a structured 180-day plan, and Amends to Self puts the person who lived through it first.

Turn to: Supp. Ch. 29 (How to Recover from Chemsex). Supp. Ch. 31 §§4 and 6 (what you will experience; special populations). Supp. Ch. 42 (Full Inventory). Supp. Ch. 43 (Amends to Self). Centurian Paper C-28 (The Recast). Compendium Protocol 23 (Rebuilding the Ledger), Protocol 24 (Returning to Work), Protocol 22 (The Family Field), Protocol 16 (The Isolation Spiral), Protocol 25 (The Open Door). Supp. Ch. 51 (Family & Support Network Guide): give it to the people who love you.

Step 10 — The long game (Year 1 to Year 10)

The Kernel maps the first 12 to 18 months of GHB recovery in detail. After that, navigation shifts from repair to stewardship. Section 4 shows how. Standing tools: Supp. Ch. 44 (The Transplant: redirect the devotion and daily structure the drug required into a practice that grows). Supp. Ch. 6 (Stay Non-Addicted) and Compendium Protocol 02 (Behavioral Addictions, with its "Mask Change" caution on addiction transfer). Compendium Protocol 13 (The Pharma Trap, a regular review of whether each medication is still needed). Supp. Ch. 38. Supp. Ch. 5, Step 6 (a weekly AI check-in profile, a reasoning tool and never a provider).

4. How navigation changes at Years 3, 5, and 10

Shading shows how much attention each track needs. Darkest is primary focus, then active, then maintenance. White cells with gray text are standing safeguards: low effort, never dropped. Numbers in brackets refer to the shifts listed below the table.

Track	Months 0–24 (foundation)	Year 3 (consolidate)	Year 5 (build out)	Year 10 (steward)
Safety and medical	Supervised detox; never alone	Close out bridge medication with a taper [1]	Tell every prescriber	No mixing, no stockpile, ever [7]
Biology and genome	GABRA2 first; methylation base	Retest labs; step stack to upkeep [2]	Prescriber card: GABRA2, CYP2C19	Re-check with new meds and age
Cues and environment	Cue removal: apps, venues, supply	Novel cues still surface	Triggers shift to social contexts: parties, sex [5]	Same plan, rehearsed

Track	Months 0–24 (foundation)	Year 3 (consolidate)	Year 5 (build out)	Year 10 (steward)
GABA and regulation	Breathwork, cold, daily exercise	Own GABA carries the load [3]	Practice is a lifestyle	Yoga, meditation, still daily
Sleep and anxiety	Rebuild sleep; anxiety waves	Waves rare; sleep restored	Anxiety plan, clinician-led	Stress plan, sleep habits
Identity and context	Identity from month 2; sexual health if chemsex	Inventory; amends to self	Sober community established	Annual re-inventory
Meaning and Manning	Purpose: first seeds only	Transplant; return to work [4]	Manning: mentor, peer support [6]	Mentor or run a group

The seven shifts

1. **Year 3, close out the bridge.** If a benzodiazepine or baclofen bridge was part of your recovery, it should now have ended with a clinical taper, not a calendar date (Supp. Ch. 31 §8). From here, any new anxiety gets evaluated as anxiety, with the GHB history disclosed, and any prescription carries a review date. Compendium Protocol 13 gives the review questions.
2. **Year 3, the stack moves from building to upkeep.** GABA-B receptor recovery reaches substantial completion around 12 to 18 months (Supp. Ch. 31 §2). Retest labs (Supp. Ch. 5 Step 1a) and step down toward maintenance. The Trinity chapter says supplements are taken until stable, then tapered and resumed if the system destabilizes; Main Book Ch. 2 treats MTHFR support as maintenance, not cure. Step down to maintenance, not to zero.
3. **Year 3, your own GABA carries the load.** The Kernel describes months 6 to 18 and beyond as a genuinely different baseline: a nervous system running on its own regulation again (Supp. Ch. 10 §3.3). Breathwork, cold, exercise, and stillness stop being emergency tools and become ordinary life.
4. **Year 3, meaning moves up.** As the repair tracks drop to maintenance, redirect the devotion and daily structure the drug required into a practice (Supp. Ch. 44) and return to work (Compendium Protocol 24).
5. **Year 5, triggers shift to social contexts.** As cue-driven craving fades, the remaining exposure is the contexts the Kernel names as GHB entry points: parties, festivals, sexual settings, and celebrations (Supp. Ch. 31 §6; Ch. 10 §5). Keep Protocol 21 ready.
6. **Year 5, Manning.** This is the Trinity's third stage (Supp. Ch. 2). The Kernel notes that people who need GHB recovery are often invisible to the systems that would help them (Supp. Ch. 10, A Final Word), so peer support and mentoring have real value here.
7. **Year 10, GABAergic substances stay off the table.** The Kernel identifies GABRA2 high-risk carriers as a "Hard Fail" profile for combining alcohol with GABAergic agents, and its Protocol 02 warns of addiction transfer, the "Mask Change" (Supp. Ch. 10 §2; Compendium Protocol 02). With no antidote and

unpredictable concentration, the no-mixing and no-stockpile rules (Supp. Ch. 31 §7) stay permanent.

What is sourced and what is extrapolated. *Shifts 1, 3, and 7 rest directly on Kernel text. Shifts 2 and 6 apply Kernel rules at a timing chosen for this guide. Shifts 4 and 5 are extrapolations. The Kernel's detailed GHB timeline ends at about 12 to 18 months, and its WHEN Correlator puts deep-root reversal at 2 to 5 or more years. Years 3, 5, and 10 are therefore projections.*

5. What outcome to expect

The short version

If you do the route above, with triage and supervised detox first, the biological foundation after that, cue removal, a sustained rebuild of your own GABA, careful handling of sleep and anxiety, and then context, identity, and purpose work, this is the outcome the Kernel projects:

- **You get through the medical window.** No unsupervised stop at a dependent level, ER-level care for seizure or delirium, and a bridge medication that ends by taper with follow-up booked.
- **The central GABA restoration takes 3 to 6 months, and substantial receptor recovery 12 to 18 months or more.** Anxiety waves and night waking thin out. The Kernel calls the result a different baseline, not just symptom absence: a nervous system regulating itself again.
- **The timeline is longer than for any other substance in the library.** In the Trinity's terms, Clarity and Restoration come first, and Manning follows once the system is rebuilt. Do not expect the generic 12-month homeostasis benchmark.
- **By years 3 to 5 the work is maintenance and building. By year 10 you are a steward,** carrying a small set of standing safeguards.

The Kernel does not promise zero risk or that a return to use cannot happen. It states that GHB has no antidote, that the withdrawal is the hardest in its library, and that supports should not be tapered early.

Milestones, in order

Milestone	When	Expected outcome	Source	Basis
Get through the medical window	Days 0–7 (dependent use)	Monitored detox. Seizure and delirium managed. No unsupervised stop.	Supp. Ch. 10 §3; Ch. 31 §§0–2	Clinical fact
Acute withdrawal resolves	Days 3–7	Physical symptoms improve and confusion clears. Depression, fatigue, and insomnia emerge.	Supp. Ch. 10 §3.3	Clinical timeline
Cross the 30-day cliff	About day 30	Bridge medication ends by taper, with a follow-up already booked. No second withdrawal landing on the first.	Supp. Ch. 31 §8	Kernel projection

Milestone	When	Expected outcome	Source	Basis
Post-acute anxiety waves	Weeks 1–12	Anxiety (often severe in weeks 1 to 2), poor sleep, and fog, easing as practice continues. Night waking at the old dosing times fades.	Supp. Ch. 10 §3.3; Ch. 31 §2	Kernel projection
Central GABA restoration	Months 1–6	Waves decrease in frequency and intensity. Breathwork, exercise, and the supplement protocol set how severe PAWS is.	Supp. Ch. 10 §7; Ch. 31 §2	Kernel projection
Receptor recovery	Months 6–18+	GABA-B receptor density largely recovered. Dopamine normalized. Near-normal anxiety tolerance. Cravings contextual.	Supp. Ch. 10 §3.3; Ch. 31 §3	Kernel projection
PAWS window closes	Up to 12–18 months	Episodic severe anxiety and sudden craving become rare. The Kernel notes GHB PAWS may be among the most protracted.	Supp. Ch. 10 §3.4	Kernel projection
Deep-root reversal	2–5+ years	Prefrontal recovery and epigenetic reversal continue. Some changes may be partial.	Supp. Ch. 36	Kernel projection
Steward phase	Years 3–10	Repair tracks at maintenance. Purpose and service. Standing safeguards.	Section 4 of this guide	Extrapolated

The Kernel's own 12-month numbers for one GHB profile

Supplemental Chapter 2 gives projected outcomes at 12 months for an adherent protocol compared with standard treatment. Case 10 is a 27-year-old from circuit-party culture, using GHB three to four nights a week, with two blackouts after being given more than expected. His profile is GABRA2 high-risk plus a COMT Worrier (slow-clearance) pattern. Note that this is a frequent-user profile, not a Level 5 around-the-clock dependent user.

Case	Measure	Kernel protocol	Standard treatment
Case 10	GHB cessation at 12 months with the full GABA support stack	63%	20%
Case 10	Social function maintained without GHB at Month 6	68%	30%
Case 10	Anxiety managed without chemical assistance at Month 6	72%	15%
Case 10	Zero unplanned blackout events from Month 1 forward	85%	60%

How to read these numbers. *The Kernel describes them as archetype projections, "probability estimates" for an adherent, biologically confirmed 12-month protocol. They are not guarantees, and the Main Book states that it is not reporting a randomized controlled trial of the Kernel itself. The Kernel's own case basis cites a standard baseline of under 20% GHB cessation without medical support.*

What changes the outcome

- **Stopping abruptly at a dependent level without medical care.** This is the highest-mortality error in the whole guide.
- **Ending a bridge medication on a calendar date instead of a clinical taper.** The 30-day cliff is a foreseeable, documented relapse point.
- **An open-ended benzodiazepine for post-GHB anxiety,** prescribed without knowing the GHB history.
- **Alcohol or other depressants.** Both are GABAergic. For GABRA2 high-risk carriers the combination is the Kernel's "Hard Fail."
- **A stockpile, or unlabeled supply, within reach.** Concentration is unpredictable, and there is no reversal agent.
- **Using alone.** If exclusion from a venue or community moves use into private, no one is present to recognize an overdose.
- **Tapering supports early, or expecting a short timeline.** The Kernel says the central phase is not the time to reduce support.
- **A lapse.** The Kernel treats it as information, not judgment (Protocol 21). It is also an overdose-risk event with no antidote: do not use alone, call 911 for unresponsiveness, and if you have returned to dependent-level use, go back to supervised detox rather than stopping on your own.

How to read the evidence behind the outcomes

The Main Book marks claims with an Evidence Tier: Established, Probable, Emerging, Author/System Experience, and Controversial or Mixed. This guide's reading: the danger of GHB withdrawal, the absence of an antidote, and the added risk of combining GHB with alcohol or other depressants are well-established clinical facts. The Kernel calls baclofen the most evidence-supported withdrawal treatment and notes that no FDA-approved GHB-specific treatment exists. The supplement stack, the natural-GABA claims, the percentage projections, and the years 3 to 10 trajectory sit lower on that scale, so bring them to your clinician as questions, not as facts. The peptide layer is labeled as needing physician discussion.

Take these to your clinician

- A complete and honest use history: which form (GHB, GBL, 1,4-BD, sodium oxybate), how often, and whether you dose overnight. The Kernel notes that under-reported use leads to under-treated withdrawal.
- Your GABRA2, CYP2C19, and CYP3A4 results, and any COMT and MTHFR results.
- A booked follow-up appointment dated before any bridge medication runs out, and a request for a taper, not a hard stop.
- A statement that any anxiety began after stopping GHB and that your nervous system may still be recovering, with a request that anything prescribed carry a review date.

- Every supplement you take, with doses, so interactions with baclofen or benzodiazepines can be checked. If you take sodium oxybate for narcolepsy, involve your neurologist before any change.